

## *The KC Cardiomyopathy Questionnaire*

The following questions refer to your **heart failure** and how it may affect your life. Please read and complete the following questions. There are no right or wrong answers. Please mark the answer that best applies to you.

- Heart failure** affects different people in different ways. Some feel shortness of breath while others feel fatigue. Please indicate how much you are limited by **heart failure** (shortness of breath or fatigue) in your ability to do the following activities over the past 2 weeks.

Place an **X** in one box on each line

| Activity  | Extremely Limited        | Quite a bit Limited      | Moderately Limited       | Slightly Limited         | Not at all Limited       | Limited for other reasons or did not do the activity |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Dressing yourself                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |
| Showering/Bathing                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |
| Walking 1 block on level ground                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |
| Doing yardwork, housework or carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |
| Climbing a flight of stairs without stopping    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |
| Hurrying or jogging (as if to catch a bus)      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                             |

- Compared with 2 weeks ago, have your symptoms of **heart failure** (shortness of breath, fatigue, or ankle swelling) changed?

My symptoms of **heart failure** have become...

|                          |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Much worse               | Slightly worse           | Not changed              | Slightly better          | Much better              | I've had no symptoms over the last 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                   |

3. Over the past 2 weeks, how many times did you have **swelling** in your feet, ankles or legs when you woke up in the morning?

- |                          |   |                          |                          |                             |
|--------------------------|---|--------------------------|--------------------------|-----------------------------|
| Every morning            | 3 or more times a week, but not every day | 1-2 times a week         | Less than once a week    | Never over the past 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/>                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    |

4. Over the past 2 weeks, how much has **swelling** in your feet, ankles or legs bothered you?

It has been ...

- |                             |                               |                              |                            |                              |                             |
|-----------------------------|-------------------------------|------------------------------|----------------------------|------------------------------|-----------------------------|
| <b>Extremely</b> bothersome | <b>Quite a bit</b> bothersome | <b>Moderately</b> bothersome | <b>Slightly</b> bothersome | <b>Not at all</b> bothersome | I've had <b>no swelling</b> |
| <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>     | <input type="checkbox"/>   | <input type="checkbox"/>     | <input type="checkbox"/>    |

5. Over the past 2 weeks, on average, how many times has **fatigue** limited your ability to do what you want?

- |                          |                          |                          |  |                          |                          |                             |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| All of the time          | Several times per day    | At least once a day      | 3 or more times per week but not every day | 1-2 times per week       | Less than once a week    | Never over the past 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    |

6. Over the past 2 weeks, how much has your **fatigue** bothered you?

It has been ...

- |                             |                               |                              |                            |                              |                            |
|-----------------------------|-------------------------------|------------------------------|----------------------------|------------------------------|----------------------------|
| <b>Extremely</b> bothersome | <b>Quite a bit</b> bothersome | <b>Moderately</b> bothersome | <b>Slightly</b> bothersome | <b>Not at all</b> bothersome | I've had <b>no fatigue</b> |
| <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>     | <input type="checkbox"/>   | <input type="checkbox"/>     | <input type="checkbox"/>   |

7. Over the past 2 weeks, on average, how many times has **shortness of breath** limited your ability to do what you wanted?

- |                          |                          |                          |  |                          |                          |                             |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| All of the time          | Several times per day    | At least once a day      | 3 or more times per week but not every day | 1-2 times per week       | Less than once a week    | Never over the past 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    |

8. Over the past 2 weeks, how much has your **shortness of breath** bothered you?

It has been ...

|                                |                                  |                                 |                               |                                 |  |
|--------------------------------|----------------------------------|---------------------------------|-------------------------------|---------------------------------|--|
| <b>Extremely</b><br>bothersome | <b>Quite a bit</b><br>bothersome | <b>Moderately</b><br>bothersome | <b>Slightly</b><br>bothersome | <b>Not at all</b><br>bothersome | I've had <b>no</b><br><b>shortness of breath</b> |
| <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/>        | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>                         |

9. Over the past 2 weeks, on average, how many times have you been forced to sleep sitting up in a chair or with at least 3 pillows to prop you up because of **shortness of breath**?

|                          |  |                          |                          |                                |
|--------------------------|--|--------------------------|--------------------------|--------------------------------|
| Every night              | 3 or more times a<br>week, but not every day | 1-2 times a<br>week      | Less than once<br>a week | Never over the<br>past 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/>                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |

10. **Heart failure** symptoms can worsen for a number of reasons. How sure are you that you know what to do, or whom to call, if your **heart failure** gets worse?

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>Not at all</b> sure   | <b>Not very</b> sure     | <b>Somewhat</b> sure     | <b>Mostly</b> sure       | <b>Completely</b> sure   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. How well do you understand what things you are able to do to keep your **heart failure** symptoms from getting worse? (for example, weighing yourself, eating a low salt diet etc.)

|                             |                                |                          |                          |                          |
|-----------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|
| Do not understand<br>at all | Do not understand<br>very well | Somewhat<br>understand   | Mostly<br>understand     | Completely<br>understand |
| <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. Over the past 2 weeks, how much has your **heart failure** limited your enjoyment of life?

|  |  |  |   |   |
|--|--|--|---|---|
| It has <b>extremely</b><br>limited my<br>enjoyment of life | It has limited my<br>enjoyment of life<br><b>quite a bit</b> | It has<br><b>moderately</b><br>limited my<br>enjoyment of life | It has <b>slightly</b><br>limited my<br>enjoyment of life | It has <b>not limited</b><br>my enjoyment of<br>life at all |
| <input type="checkbox"/>                                   | <input type="checkbox"/>                                     | <input type="checkbox"/>                                       | <input type="checkbox"/>                                  | <input type="checkbox"/>                                    |

13. If you had to spend the rest of your life with your **heart failure** the way it is right now, how would you feel about this?

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all<br>satisfied  | Mostly<br>dissatisfied   | Somewhat<br>satisfied    | Mostly<br>satisfied      | Completely<br>satisfied  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14. Over the past 2 weeks, how often have you felt discouraged or down in the dumps because of your **heart failure**?

I felt that way **all of the time**    I felt that way **most of the time**    I **occasionally** felt that way    I **rarely** felt that way    I **never** felt that way

                                                                                      

15. How much does your **heart failure** affect your lifestyle? Please indicate how your **heart failure** may have limited your participation in the following activities over the past 2 weeks.

Please place an **X** in one box on each line

| <b>Activity</b>                             | <b>Severely limited</b>  | <b>Limited quite a bit</b> | <b>Moderately limited</b> | <b>Slightly limited</b>  | <b>Did not limit at all</b> | <b>Does not apply or did not do for other reasons</b> |
|---|--------------------------|----------------------------|---------------------------|--------------------------|-----------------------------|---|
| Hobbies, recreational activities            | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>                              |
| Working or doing household chores           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>                              |
| Visiting family or friends out of your home | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>                              |
| Intimate relationships with loved ones      | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>                              |